DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/05/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION IG 01 - MAIN BUILDING 01	COMPL	
		445445	B. WIN	1G		11/3	28/2011
NAME OF F CELINA (X4) ID PREFIX TAG	PROVIDER OR SUPPLIER HEALTH AND REHAL SUMMARY STA (EACH DEFICIENCY REGULATORY OR LEAST A one half hore accordance with 8. terminate at an atri protected by fire-ra panels and steel fra separate comparting floor. Dampers are penetrations of sm heating, ventilating 19.3.7.3, 19.3.7.5, This STANDARD Based on observa	IDENTIFICATION NUMBER:		STREET ADDRESS, CITY, STATE 120 PITCOCK LANE CELINA, TN 38551 PREFIX TAG PROVIDER'S PLAN (EACH CORRECTIVE CROSS-REFERENCED DEFIC K025 1. The penetrative repaired by the Maintenance inserviced on regarding mass make barrie 2. The remaining inspected on Director of Mensure that the penetrations. 3. The maintenative regarding mass inserviced regarding mass inserviced regarding mass penetrations to barriers by the samine the accordance of the maintenative regarding mass penetrations to barriers by the samine the accordance of the maintenative regarding mass penetrations to barriers by the samine the accordance of the maintenative regarding mass penetrations to barriers by the samine the accordance of the maintenative regarding mass penetrations to barriers by the samine the accordance of the maintenative regarding mass penetrations to barriers by the samine the accordance of the maintenative regarding mass penetrations to barriers by the samine regarding mass penetrations are samined to the		RECTION SHOULD BE PPROPRIATE THE COT OF STATE S	ETED
SS=D	revealed 10 ceiling attic. This finding was addirector of mainten conference on 11/2 NFPA 101 LIFE SA Exit access is arrai accessible at all tin 7.1. 19.2.1	attic on 11/28/11 at 10:35 AM, penetrations throughout the cknowledged administrator and ance during the exit 28/11. AFETY CODE STANDARD aged so that exits are readily nes in accordance with section		038	four weeks and then for two months or un compliance is achieve thereafter to according facilities preventative maintenance plan. A will be reported by to Maintenance Director Quality Assurance Performance Improve committee comprises Medical Director,	ntil 100% yed and ng to the e All results he or to the	(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEC 16 2011

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING 01 - MAIN BUILDING 01		COMPLETED	
445445		B. WING			11/28/2011		
NAME OF PROVIDER OR SUPPLIER CELINA HEALTH AND REHABILITATION CENTER				12	EET ADDRESS, CITY, STATE, ZIP CODE 20 PITCOCK LANE ELINA, TN 38551		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	/ MUST BE PRECEDED BY FULL	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPLICATION OF THE APPL	OULD BE ROPRIATE	(X5) COMPLETION DATE
K 038	This STANDARD is Based on observatine facility failed to exit discharge to the The findings included Observation of the 10:39 AM, revealed public way was observation of the series of the exit conferent NFPA 101 LIFE SAR Required automatic valves supervised will sound when the 72, 9.7.2.1 This STANDARD Based on observatine facility failed to The findings included.	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Intinued From page 1 IS STANDARD is not met as evidenced by: Issed on observations, it was determined that If acility failed to maintain the access from the It discharge to the public way. Is findings included: Is servation of the 100 corridor on 11/28/11 at If any		038 061 K	Administrator, Director Nursing, Staffing Coordinator, Minimum Set Coordinator, Social Services, Activities Di Dietary Manager, and Housekeeping Supervities and Housekeeping Supervities 11/28/11. The maintent department was inservities 11/28/11 regarding professes to exit corridors Administrator. 2. The remaining exits were inspected on 11/28/11 Director of Maintenance insure that there are no obstructions. 3. The maintenance department managers, in the maintenance department managers, in the superiment managers are superiment managers.	the ce on ance iced on per by the ce to other ment,	Completion Date 12/22/11
	This finding was ac	This finding was acknowledged by the					

		AND HUMAN SERVICES	207				12/05/2011 APPROVED		
	CONTROL CONTRO		454		1-15-12	OMB NO. 0938-0391			
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A Common		CONSTRUCTION	(X3) DATE SU COMPLE				
			A. BUI	LDING	01 - MAIN BUILDING 01				
		445445	B. WII	VG		11/28/2011			
NAME OF P	ROVIDER OR SUPPLIER			STREE	T ADDRESS, CITY, STATE, ZIP CODE				
CELINA	HEALTH AND REHAE	SILITATION CENTER		E management	PITCOCK LANE				
	CUMMA DV OTA			ID PROVIDER'S PLAN OF CORRECTION (X5)					
(X4) ID PREFIX TAG				ıx	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	/E ACTION SHOULD BE COMPLETION DATE			
K 061	Continued From pa administrator and d exit conference on	irector of maintenance at the	K	061					
					assistants and licensed nustaff were inserviced beg 11/28/11 through 12/12/1 regarding proper access to the Administrator. 3. The maintenance dire examine the exit corriweekly for four week then monthly for two or until 100% complicatived and thereafte according to the facility preventative maintenary plan. All results will reported by the Maint Director to the Quality Assurance Performant Improvement commit comprised of the Med Director, Administrate Director of Nursing, S. Coordinator, Minimum Set Coordinator, Minimum Set Coordinator, Social Services, Activities D. Dietary Manager, and Housekeeping Superventees.	inning 1 o exits o exits octor will idors s and months ance is er ities ance be enance y ce tee lical or, Staffing m Data al irector,			
					Trousekeeping Superv				

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01		COMPLETED		
	445445 B. WING 11/2		11/28/2011				
NAME OF PROVIDER OR SUPPLIER CELINA HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 120 PITCOCK LANE CELINA, TN 38551				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE COMPLETION		
K 038	This STANDARD Based on observathe facility failed to exit discharge to the The findings include Observation of the 10:39 AM, revealed public way was observation was administrator and at the exit conferent NFPA 101 LIFE SAR Required automatically valves supervised will sound when the 72, 9.7.2.1 This STANDARD Based on observation of the facility failed to The findings include Observation of the 105 on 11/28/11 at black flow prevent connected to the finding to the facility failed to the finding to the facility for the findings include the facility failed to the facility failed to the facility failed to the findings include the facility failed to the facili	is not met as evidenced by: tions, it was determined that maintain the access from the le public way. led: 100 corridor on 11/28/11 at d the exit discharge to the structed by a patient lift. cknowledged by the director of maintenance during nce on 11/28/11 AFETY CODE STANDARD c sprinkler systems have so that at least a local alarm e valves are closed. NFPA is not met as evidenced by: tions, it was determined that maintain the sprinkler system. led: sprinkler riser system in room t 10:45 AM, revealed that the or monitoring switches were not	K 06	1. The monitoring switched connected by the reparation on 12/22/11 2. The remaining automates sprinkler systems were inspected on 11/28/11 Director of Maintenance deparation of the maint	tic tic te I by the nce to no other lentified. rtment /28/11 nitoring ms by the ctor will c ekly for monthly nat all or until nchieved ing to the I results e to the mmittee lical or,		

Event ID: QSDD21

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUI	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING			(X3) DATE SURVEY COMPLETED	
		445445	B. WIN	1G		11/28/2011		
	ROVIDER OR SUPPLIER	ABILITATION CENTER		120	ET ADDRESS, CITY, STATE, ZIP CODE PITCOCK LANE LINA, TN 38551			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
K 061		director of maintenance at the	K 061		Coordinator, Minimum Coordinator, Social Servactivities Director, Diet Manager, and Housekee Supervisor.	vices, ary		
					6.2			